

SHAPING MIGS DELIVERY

What's the subspecialist's role?

BY RONALD L. FELLMAN, MD



As glaucoma subspecialists, our major role is to teach the ophthalmic community how to select the best IOP-reducing procedure to save patients' vision in the safest manner possible. This is not an easy job, because devastating complications may occur during and after glaucoma surgery, which is of great significance for monocular patients. Our

knowing which procedure to avoid may dictate the most favorable result, but this requires considerable clinical and surgical experience and judgment. Comprehensive anterior segment surgeons must learn how best to counsel their patients regarding glaucoma surgery, including microinvasive glaucoma surgery (MIGS) options—much as these doctors do regarding IOL selection. The key is to tailor the procedure to the needs and lifestyle of each patient, something that takes time to learn.

In the meantime, pending more long-term data and better pre- and intraoperative diagnostic tests for guidance, we have nine tasks.

TASK No. 1 COMMUNICATE REGARDING CANDIDACY



We must communicate which patient is the best candidate for a particular device or treatment. For example, successful canal-based MIGS depends on the downstream integrity of the

trabecular outflow system, yet we do not have advanced imaging of the outflow pathway. If such technology indicated that the downstream collector channels (back wall collector entrances and distal to Schlemm canal) were atrophic, then it would be prudent to abandon a canal-based procedure and go directly to either a suprachoroidal or subconjunctival procedure (tube, filter, or "MIGS plus" to create an artificial drain). Until diagnostic outflow technology exists, our role is to teach comprehensive anterior segment surgeons that patients with advanced glaucoma are likely better candidates for procedures that create a new drainage system for their eye (usually because their natural drains are too atrophic), whereas those with mild to moderate disease (their drainage system is still salvageable) may be reasonable candidates for enhancement of their natural drain with a canal-based surgery.

TASK No. 2 TEACH THE BEST WAY TO TRANSITION TO MIGS



MIGS is one of the few ophthalmic procedures I can think of where surgeons use their dominant hand for a delicate intracameral angle maneuver while balancing a lens on the cornea at the same time with their nondominant hand

to see what they are doing. The nondominant hand holding the gonioscope is in control of the view necessary to properly perform the procedure. Thus, potentially for the first time, ophthalmologists depend on their nondominant hand to obtain the necessary view to succeed.

MIGS requires a totally different set of proprioceptive skills than phacoemulsification, where the tips of instruments are visualized at the same time through the operating microscope. This is not the case with MIGS; only one instrument is directly visualized through the microscope. I encourage ophthalmologists to start out by purchasing a gonioscope and practicing intraoperative gonioscopy on a routine basis by tilting the patient's head and microscope and visualizing the angle with the gonioscope to mimic the feel of this new proprioceptive exercise (see *Watch It Now*).

TASK No. 3 INVOLVE YOUNGER AND INTERESTED OPHTHALMOLOGISTS



We can ask younger colleagues to assist us on MIGS cases so that they may learn many of the intricacies related to angle surgery. Unfortunately, this luxury is not available to



AT A GLANCE

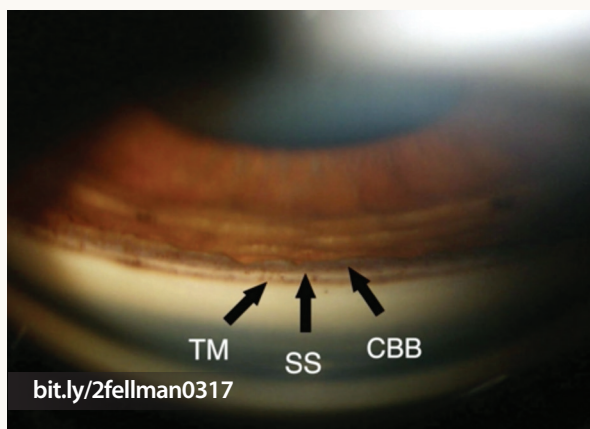
- Glaucoma subspecialists' major role is to teach the ophthalmic community how to select the best IOP-reducing procedure to save patients' vision in the safest manner possible.
- The key is to tailor surgery to the needs and lifestyle of each patient, something that takes time to learn.
- Pending more long-term data and better pre- and intraoperative diagnostic tests for guidance, the author says subspecialists have nine tasks.

WATCH IT NOW

In this episode of Glaucoma Today Journal Club, Nathan Radcliffe, MD, shares advice on how to select the appropriate microinvasive glaucoma surgical procedure for each patient.



Shakeel Shareef, MD, covers key points of intraoperative gonioscopy for MIGS surgeons.



most ophthalmologists. I encourage physicians interested in learning MIGS to observe surgeons experienced in the desired procedure(s). In addition, many companies offer programs to help surgeons learn their procedure.

TASK No. 4 REVIEW CLINICAL TRIAL OUTCOMES WITH COLLEAGUES



An underutilized but extremely helpful practice is reviewing the outcomes of MIGS clinical trials with colleagues. The fine details related to a study that translate into clinical care are often-times best elucidated at an informal meeting

such as a journal club or in a roundtable atmosphere. That said, learning about new procedures at major meetings is always useful.

TASK No. 5 SHARE TIPS THROUGH VIDEOS



We can widely disseminate our best pearls and techniques for inserting or using a specific device by producing videos and sharing them through forums such as Eyetube.net and professional meetings. Unfortunately, surgeons usually show their best cases!

TASK No. 6 EMPHASIZE THE IMPORTANCE OF GONIOSCOPY



We must teach gonioscopy and encourage physicians to take courses on angle anatomy prior to their OR experience (see *Watch It Now*). Routinely performing gonioscopy will give them a better understanding of angle anatomy, which will facilitate device implantation. During gonioscopy in the clinic, it is worth their pausing to ask, "Where is the scleral spur?"

TASK No. 7 HELP TRAIN RESIDENTS AND FELLOWS



We can educate the next generation on the various techniques at this crucial early phase of their career.

TASK No. 8 EXPLAIN YOUR THINKING



Let's explain our rationale for a particular procedure to the patient and the referring physician during glaucoma consultations. This is an excellent teaching tool (see *Watch It Now*).

TASK No. 9 KEEP YOURSELF AND THE OPHTHALMIC COMMUNITY UPDATED



Considering that there are currently nine canal-based MIGS procedures, it is incumbent on us to continue to evaluate them in light of what is best for our patients and then to rapidly inform the ophthalmic community of our findings, at least through published research and meetings. ■

Ronald L. Fellman, MD

- glaucoma specialist, Glaucoma Associates of Texas, Dallas
- clinical associate professor emeritus, Department of Ophthalmology, UT Southwestern Medical Center, Dallas
- adjunct professor, North Texas Eye Research Institute, University of North Texas Health Science Center, Fort Worth
- (214) 360-0000; rfellman@glaucomaassociates.com